HEALTH FACILITY COMMITTEE MEETING
Cannon Health Building, Room 125
9:00 a.m., August 25, 2000

Members Present: Kathleen Fitzgerald; Kathy Siskin; Glade Bigler; Paul Clayton; Travis Jackman; Steve Bateman; Gayle Morowitz; Timothy Thomas; and Joyce Wanta; Hellen Rollins; Leora Medina; and Lou Ann Jorgensen.

Staff: Debra Wynkoop; David Eagar; Wendee Pippy; Pennie Knudson and Joan Isom.

The meeting was called to order at 9:03 a.m.

1. **Welcome**:
   Ms. Wynkoop expressed her appreciation for all the Health Facility Committee members whose terms had expired, and especially Helen Rollins and Steve Bateman who had chaired and co-chaired the committee.

2. **May 19, 2000, Minutes**:
   Dr. Clayton made a motion to accept the May 19, 2000, minutes with no amendments or changes. Kathy Siskin seconded the motion. The **MOTION PASSED** unanimously.

3. **Licensure Actions/Sanctions**:
   David Eagar reported on the Licensure Sanctions/Actions for the Southern Region, Northern and Dixie Regions. (See attached chart on License Sanctions/Actions.)

4. **Sub-Committee Reports**:
   a. **Assisted Living**:
      Ms. Siskin explained the proposed changes to the Assisted Living Rule.
      Ms. Morawetz questioned whether bed rails were acceptable. Ms. Wynkoop explained that bed rails are considered restraints but if the residents were able to raise and lower the rails themselves and had requested the bed rails then they would be permissible. Ms. Morawetz stated that she knew of an instance where a bed with rails was brought into a facility and the facility would not allow them to use the bed. Ms. Wynkoop stated that there are serious concerns of death and entrapment when the bed rails are used. No rule change was adopted.

Dr. Clayton expressed concern about the lack of specifics in the rule for the administration and disposal of narcotics in the assisted living facilities. Dr. Clayton stated that because another provider has an opportunity to divert the medications, the rule should be stricter. Ms. Wynkoop stated that the Department would incorporate a reference in the rule to comply with the Drug Enforcement Policy.

Mr. Gary Taylor, Utah Assisted Living Association (UALA) expressed his appreciation for the work of the assisted living sub-committee. He stated that UALA has reviewed the proposed rules and expressed their support.
Ms. Morawetz made a mothion that the proposed assisted living rule be accepted. Ms. Siskin seconded the motion. The **MOTION PASSED** unanimously.

b. Ambulatory Surgical Centers:
Dr. Clayton reported that the Ambulatory Surgical Center Sub-committee had met once since the last Health Facility Committee Meeting. He reported that the Utah Society of Anesthesiologists had presented a new rule draft proposal, which was very similar to the proposal that the nurse anesthetists had proposed. The sub-committee has tried to find areas of consensus and to resolve areas of conflict. The sub-committee's next meeting is scheduled for September 19, 2000.

5. **Update on Medicaid Demonstration Project**:
Mr. Don Fenimore reported on the history and progress of the Medicaid Demonstration Project which is operated as Flex Care by Valley Mental Health as of April 1, 2000. Mr. Fennimore stated that currently 14 residents are admitted and 13 others are being assessed for enrollment. Flex Care is designed to be a Long- Term care demonstration project for residents 18 years or older who are currently served by nursing care facilities. To be eligible, the resident must come from a long-term care facility or is being discharged from a hospital and the placement would be in a nursing care facility. Referrals are received from nursing care facilities, discharge planners and family members. Each referral receives an assessment to determine what level of care and services would be needed to provide the least restrictive setting. A plan of care is developed to include home health, occupational therapy, or physical therapy.
A second characteristic that makes this project different is that they are able to use Medicaid dollars to pay for room and board, which allows a resident to receive services in Assisted Living settings.
Mr. Fennimore said that this project is limited to 500 residents and all funding is managed through United Health Care, an HMO. The HMO coordinates services with estate planners, primary care physicians, and a social work care manager. The project also has a contract with a moving company to assist the move to another facility. Most of the residents will be placed in either assisted living II or I's, but some may have the option to be placed in a family member's home. There are funds available to pay family members to provide attendant care.

Mr. Fennimore stated that another characteristic that makes this project different is that a resident will have a case manager, as an advocate, who will coordinate the care and services with the resident.
The project hopes to develop a continuum of care within long term care settings, so that there is a smoother transition between long-term care settings.
Referrals may be made by calling (801) 263-7116.
Dr. Clayton questioned the time frame of the demonstration and will it be ongoing?
Mr. Fennimore responded stating that the project was designed as a three-year demonstration project and an evaluation of the quality of life, quality of care, and financial viability will be conducted. The project should have 200 residents by the end of next year and if the quality of life of the individuals has vastly improved, then the project was a success and the State will apply for a permanent waiver. Mr. Fennimore reported that he had the opportunity to interview all of the enrolled residents, who have expressed that the biggest improvement is their sense of control over their life again.
Ms. Morawetz asked how do patients come in contact with the project and what is the outreach for the program?
Mr. Fennimore reported educational meetings have been held with discharge planners in Salt Lake and Davis County. The project is centralized to develop policies and procedures for the operation. If the project becomes a permanent waiver then services could be statewide.
Ms. Wynkoop reported on the Olmstead Grant which stems from a Supreme Court decision which allows an individual the freedom to choose a health care or home setting, if they are deemed capable of living in a community setting. Medicaid will be responsible for funding the alternative. A Grant for $200,000 has been awarded to Utah for Transitional Assessments.
Mr. Fennimore reported that a second grant, the Nursing Home Transition Grant, of $455,000, would be used to design a triage system for long term care, so that people who will be placed in the long term care setting will have access to information on alternatives and they can then make an informed choice.

6. Update on Rules:

a. Mandatory Reporting on Adverse Events:

Dr. Bruce Murray reported that the Utah Medical Association and the Utah Hospital Association have a 30 member Patient Safety Task Force that has met four times to discuss medical error and patient safety. A proposal was made to the task force for a mandatory Patient Safety Reporting System, which was very controversial because of the potential legal ramifications. Dr. Scott William, Deputy Director of the Department of Health, proposed this reporting could be done under the existing statutory authority through the Health department through the Bureau of Licensing, Health Data Analysis, or Epidemiology or a statutory change could be made through the legislature. Dr. Murray stated that the task force would be meeting again in two weeks to give their comments to Dr. William. Ms. Wynkoop reported that Medicare has threatened to add a new Condition of Participation, the first of next year, to require mandatory reporting. Dr. Murray explained that the task force is being pro-active and they would like to

have a plan in place to promote patient safety before the federal government imposes a system.
Ms. Morawetz asked about the accountability of errors?
Ms. Wynkoop reported that a facility reports in order to correct errors and systematic problems. Individuals need to be able to report what they saw, and an analysis done to determine if there is additional training required or if the error is an isolated incident or mistake. JCAHO hospitals are already required to report "sentinel events." The reporting system should identify when someone should have discipline taken because the person acted irresponsibly or if the person made an honest mistake. Further updates will be discussed with the committee.

b. **Advance Directive Subcommittee**:
Subcommittee members all agreed that all of the current forms are unreadable and that there needs to be modifications to the statute. A form needs to have the force of law, simple language, and a place to document a change in preferences. Ms. Wynkoop researched statutory language, from other states that have modified the advance directive language in the last two years. Ms. Wynkoop stated that she believes that they may have a model this year sponsored by Senator Karen Hale. The committee will be meeting on the 31st of this month and hope to agree on a draft document.
Ms. Rollins stated that she continues to express concerns about the need to have a portability document. We will receive a further report next meeting.

c. Critical Access Hospital Concept Summary:
Ms. Wynkoop reported that Medicare has adopted a new Critical Access hospital category that rural hospitals that have 25 beds or less can participate in. Of those 25 beds, only 10 beds can be swing beds. Many of Utah's rural hospitals have been doing a community need and financial assessment to examine if changing categories would be an advantage. This creates another Specialty Hospital category to the Licensing rules. Currently a Critical Access Hospital Advisory committee has been working on a draft for the Health Facility Committee to review.
Adopting the Critical Access Hospital category may save some of our rural hospitals and improve the quality of care in those communities because it requires the hospital to have an agreement with a larger resource hospital for: 1) transfer agreements; 2) quality assurance and quality improvement agreements; and 3) credentialing. A Critical Care Hospital and resource hospital may strengthen the EMS system, including putting some Tele-health Tele-medicine programs together so there is more coordination for triage and transport. HUD funding may be available to fund a remodel of these hospitals.
Dr. Murray reported that seven rural hospitals participated in a two-part study to examine if the hospital would be better off if they converted to a critical care status. The results of the research indicated that six of the seven could actually benefit from the change to Critical Care Access status. The department has applied for another grant to study three or four more hospitals and assist six

hospitals with the transition. If a hospital has more than 25 beds, they are examining alternative licensing categories to meet the community need.
Ms. Wynkoop explained that the Medicaid moratorium would not apply to hospitals converting to Critical Access Hospitals who may seek a nursing facility license.
Dr. Murray stated that Montana has 15-16 critical access hospitals. Research is being done to analyze those states that have converted to a Critical Access category to see: 1) If there has been an impact on quality of care; 2) Did the hospital make the expected revenue increase; and 3) Impact to the delivery of services.
A copy of the Medicaid rule will be distributed at the next Health Facility Committee meeting.

d. **Design Conference**:
The Bureau of Licensing will participate in the Utah Health Care Association conference on September 12th, 13th, and 14th, 2000. Bill Bonn and Larry Naylor, from the Bureau of Licensing, will present information on trends and new designs for long term care facilities. We need to change the look of the health facility to be a home environment where the resident's needs are met with dignity and privacy.
Mr. Fennimore stated that he has discussed the need to provide privacy with several nursing home providers and that he has noticed that they have replaced curtains with partitions in bedrooms.

6. Other Business:
Ms. Rollins distributed a flyer "Dying in America" a Bill Moyers program airing on September 10, 11, 12, and 13 on channel 7. She urged members to watch the program, which deals with starting a dialog with family members about death.

7. **Rule Revision Request**:
Dr. Bruce Murray, Utah Hospital Association, presented a report that a member reported staff to patient abuse and self reported to APS, and took the necessary steps to correct the problem. However, the Bureau investigated and the hospital was issued a conditional license. Dr. Murray asked the committee to reconsider the rule on self-reporting.
Dave Gessell, Utah Hospital Association, stated that there is no incentive for self-reporting and he would like a different penalty for self-reporting. He proposed a rule to address this problem by giving the facility 10-15 days to report an incident to the Bureau and a different penalty, if the Bureau discovers an incident on their own.
Mr. Payne proposed a solution that if a facility self reports, is following their policies and procedures, and is taking appropriate disciplinary action they would not be cited but have immunity from receiving a conditional license.
Mr. Bigler questioned whether this mandatory reporting would increase lawsuits?
Dr. Murray stated that when the Patient Safety Task Force met, they discussed reporting sentinel events and how that may precipitate lawsuits.

Mr. Bateman stated that JCAHO hospitals are required to self-report sentinel events and he would urge the Bureau to examine that policy. The JCAHO and the American Hospital Association worked to develop a policy that encourages self-reporting, and ensures that those people who did not have pure motives would be penalized for not reporting. He stated this policy works very well.

Ms. Wynkoop clarified that a conditional license can only be issued if there are three or more repeat violations from a previous licensing survey, if a Conditions of Participation for Medicare is violated, if the facility fails to correct violations with a plan of correction, or if they fail to meet the administrative procedures of submitting the application. Ms. Wynkoop explained that it was not a condition of "self reporting" that caused the Utah State Hospital to receive a conditional license, it was the violation of Medicare Conditions of Participation. Ms. Wynkoop explained that the law is very clear on reporting for abuse, neglect or exploitation of children or adults and that if you suspect that this has occurred, you must report. If you fail to report, it is a Class B Misdemeanor or Class A Misdemeanor depending on the age of the individual. The rules state that a patient shall be free from abuse, neglect or exploitation. Ms. Wynkoop proposed if it is discovered during a "self reported incident" that the actions of an employee and discipline taken was appropriate, then the action would go against the employee and not the facility. A referral would be made to Department of Professional Licensing (DOPL) for investigation. The facility must prove that they had provided orientation, in-service training and that they had done a thorough investigation of the incident. Ms. Wynkoop stated that the Bureau completes 16,000 criminal background screenings on health care employees, except for hospitals who are excluded, on a yearly basis. She questioned if you have a facility that has an employee that abuses a patient in January, and that employee is terminated and then you have a different employee who abuses a patient in March, and that employee is also terminated and then it happens again in October, this would be a systems problem and a violation against the facility would be issued due to the pattern of abuse. Ms. Wynkoop explained that Adult Protective Services reports all referrals of licensed facilities to the Bureau, which includes resident to resident abuse.

Ms. Wynkoop proposed returning to the committee with a protocol that says the Bureau will take an action against the individual if the facility or hospital can demonstrate that they have done their quality improvement review, they have a system in place, they have reviewed their policies and that the system did not break down, but that it was the individual who was at fault.

Mr. Bateman explained that this is the same policy that the JCAHO has implemented and that the consequences are far worse to the facility for failure to report than if they had reported the incident themselves.

Ms. Wynkoop stated that in statute, actual harm to a patient could be assessed as a civil money penalty from $1,500.00 to $5,000.00 a day per incident to a facility.

Ms. Wynkoop discussed that the Utah State Hospital is JCAHO deemed status, the surveys are not annual, but may be every three years. The second issue would be to address chronic noncompliance for deemed status facilities.

Ms. Wynkoop explained deemed status is offered by a recognized accrediting organization. In order to be "deemed" the facility and the accrediting organization is required to share the grid scores and survey results with the Bureau and the Bureau

attends the CEO summation conference. The Bureau may ask for a plan of correction to findings made by an accrediting organization immediately, where as the accrediting organization may not send the findings to the facility for 30 days.
Ms. Siskin requested a change in the rule addressing deemed status. Ms. Wynkoop will examine and propose a change.
Ms. Rollins requested an update of the progress of the adverse actions reporting committee every two months.

8. **Conflict of Interest Statement**:
   Ms. Pippy explained that only the continuing members of the committee need to read and sign the conflict of interest statement. (See attached)

9. **Nominations**:
   Ms. Siskin made a motion that Steve Bateman take over as the chairperson until he is replaced on the committee. Dr. Jorgensen seconded the motion. Mr. Batemen stated that he thought that the motion was irrelevant because he was being released at the same time Ms. Rollins is released.
   Ms. Siskin withdrew her motion.
   Ms. Fitzgerald made a motion that Kathy Siskin be appointed as the new chair person of the Health Facility Committee. Dr. Jorgensen seconded the motion. Eleven voted in favor of the motion, one member was opposed.
   Dr. Jorgensen nominated Dr. Clayton to be the co-chairperson. Ms. Siskin seconded the motion. The **MOTION PASSED** unanimously.
   Ms. Siskin made a motion to adjourn the meeting. Mr. Bateman seconded the motion. The **MOTION PASSED** unanimously.

The next meeting will be November 17, 2000.

Meeting adjourned at 11:35 a.m.

_____ _____

Kathy Siskin, Chairperson Debra Wynkoop, Executive Secretary